SUPREME COURT

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MAY 2002

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STATE OF MICHIGAN

IN THE SUPREME COURT

APPEAL FROM THE COURT OF APPEALS
HAROLD HOOD, PRESIDING JUDGE

TERESA COX, as Next Friend of **BRANDON COX**, a Minor; **TERESA COX and CAREY COX**, Individually,

Plaintiffs-Appellees,

-vs-

BOARD OF HOSPITAL MANAGERS FOR THE CITY OF FLINT d/b/a HURLEY MEDICAL CENTER, a municipal corporation,

Defendant-Appellant.

Supreme Court Number:
118110
Court of Appeals Number:
205025
Genesee County Circuit Court
Case Number: 92-12247-NM

RICHARD D. TOTH (P21512)
Attorney for Plaintiffs-Appellees
2000 Town Center, Suite 900
Southfield, MI 48075
(248) 355-0300

ROBERT P. ROTH (P27238)
Attorney for Defendant-Appellant
3883 Telegraph Road, Suite 103
Bloomfield Hills, MI 48302
(248) 647-4242

STEPHEN N. LEUCHTMAN (P16590)
Co-Counsel for Plaintiffs-Appellees
718 Notre Dame Street
Grosse Pointe, MI 48230-1240
(313) 884-6600

PLAINTIFFS-APPELLEES' BRIEF ON APPEAL

SOMMERS, SCHWARTZ, SILVER & SCHWARTZ, P.C.
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COUNTER-STATEMENT OF QUESTIONS INVOLVED

I. DID THE CIRCUIT COURT CORRECTLY RULE THAT THE STANDARD OF CARE APPLICABLE TO NURSES STAFFING *DEFENDANT'S LEVEL III NEONATAL INTENSIVE CARE UNIT* WAS A NATIONAL STANDARD OF CARE?

Plaintiffs-Appellees, the Circuit Court, and the Court of Appeals say the answer is Yes.

Defendant-Appellant says the answer is No.

II. DID THE CIRCUIT COURT CORRECTLY EXERCISE ITS DISCRETION IN ADMITTING THE STANDARD OF CARE TESTIMONY OF PLAINTIFFS' EXPERTS?

Plaintiffs-Appellees, the Circuit Court. and the Court of Appeals say the answer is Yes.

Defendant-Appellant says the answer is No.

III. WAS THE MODIFIED VERSION OF SJI 2d 30.01 GIVEN BY THE CIRCUIT COURT APPROPRIATE UNDER THE CIRCUMSTANCES OF THIS CASE AND DID IT ADEQUATELY AND FAIRLY PRESENT THE ISSUES TO THE JURY?

Plaintiffs-Appellees, the Circuit Court, and the Court of Appeals say the answer is Yes.

Defendant-Appellant says the answer is No.

IV. DID THE COURT OF APPEALS CORRECTLY AFFIRM THE VERDICT AND JUDGMENT OF THE CIRCUIT COURT?

Plaintiffs-Appellees and the Court of Appeals say the answer is Yes.

Defendant-Appellant says the answer is No.

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COUNTER-STATEMENT OF PROCEEDINGS AND FACTS

I. UNDERLYING FACTS

This is a medical malpractice case arising out of events following the premature birth of Plaintiff Brandon Cox at Defendant Hurley Hospital on February 8, 1990. Brandon Cox was born after twenty-seven weeks gestation and weighed only 900 grams. (63a). Because of his prematurity and low body weight, he was immediately placed in the neonatal intensive care unit of the hospital. An umbilical arterial catheter (UAC) was inserted into the baby's abdomen by Dr. Brian Nolan at around 2:30 p.m. on February 8, 1990. (62a). The purpose of inserting this catheter was to monitor the infant's blood gases. The UAC was secured using a "goal post" technique of taping and abdominal sutures. (64a-65a).

Twenty hours later, at 2:20 a.m., on February 9, 1990, per a physician's order, Nurse Edith Ann Krupp pulled the catheter out two centimeters. She removed the tape, slid the catheter up the suture, and re-taped the UAC in its new position. (66a-67a). The following day, on the afternoon of February 10, 1990, at 4:00 p.m., Nurse Martha Plamondon drew blood gases from the catheter and repositioned the baby. Twenty minutes later, a respiratory therapist observed that the UAC had become dislodged and the child was bleeding and very pale. (29b). An examination of the baby's bloody diaper showed that half of the baby's blood volume had been lost (about 40 cc's of blood) between 4:00 p.m. and 4:20 p.m. (36b-36b). Nurse Plamondon applied pressure to stop the bleeding and at 4:40 p.m. gave Brandon an I.V. push of 20 cc of Plasmanate. (37b). Nurse Plamondon summoned a resident, Dr. Amy Sheeder, who arrived at 4:45 p.m. (26b). Dr. Sheeder ordered another push of 10 cc Plasmanate at 4:46 p.m. and 10 cc of

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blood at 5:00 p.m. and another 10 cc of blood at 5:45 p.m. (27b). Brandon received further treatment at Hurley Hospital until being transferred to Children's Hospital. An ultrasound performed on Brandon just three hours before this exsanguination episode had demonstrated his brain to be normal. An ultrasound, performed three days after this indicent, on February 13, 1990, indicated that Brandon had suffered an intracranial bleed and other abnormalities. (17b-18b). Brandon continues to suffer from severe mental and physical disabilities as a consequence of these events.

II. TRIAL

Plaintiffs filed their Complaint against Hurley Hospital on February 5, 1992, alleging that Defendant Hurley hospital had been negligent in allowing the UAC line to become dislodged, negligent in its response to this dislodgement, and that the subsequent blood loss contributed to Brandon Cox's severe and permanent mental and physical disabilities. On October 1, 1993 this case was mediated and the mediators awarded $475,000.00 to Plaintiffs. Plaintiffs accepted the mediation and Defendant rejected it.

Trial began on May 13, 1994 and continued to May 25, 1994. Over Defendant's objection that neither of Plaintiffs' experts were familiar with the "local" standard of care (26a-31a, 58a) the trial court permitted the opinions of Dr. Modanlou and Dr. Crawford to be admitted into evidence. Dr. Modanlou testified that in his opinion, in every NICU in the United States, the NICU nurse is responsible to make sure that the UAC is maintained to stay in place properly. (9b, 10b, 11b). He explained that the amount of blood loss found at 4:20 p.m. would indicate that the baby had been bleeding for about 20 minutes, or from the time Nurse Plamondon had repositioned the baby. (7b). He testified that it was most likely the person who attended to the baby at 4:00 p.m. who caused the line to come out

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(16b), and insisted that if proper precautions are taken the line should not come out. (12b). Dr. Crawford offered similar testimony, asserting that a properly placed and *monitored UAC should not come out (48b-50b), that it is incumbent upon the nurse after* repositioning the baby to ascertain that the UAC is in place and secure (51b), and concluding from the timing of the incident that the UAC was dislodged when the nurse repositioned the baby at 4:00 p.m. (57b).

Nurse Martha Plamondon, the NICU nurse attending to Brandon who repositioned him at 4:00 p.m., agreed that it was her responsibility to maintain and monitor the UAC. (32b).

Defendant's own standard of care expert, Dr. Stephen Donn contributed his view that Defendant's Level III NICU was "one which can provide the most complex state-of-the-art care" (66b-67b), that he would expect the standard of care at a Level III NICU to be a nationwide standard (72b-73b), and that his own testimony about Defendant was based on "general neonatology standards." (74b). He offered that the UAC could have been dislodged due to movements of the baby or loss of tape integrity due to warming lights. (67b-71b).

No witness testified that a nurse who dislodged a UAC while repositioning a baby or who failed to check its integrity thereafter, would be acting in compliance with the standard of care. With respect to the standard of care question, the only issue in dispute at trial was whether the dislodgement of the UAC resulted from negligence on the part of Defendant's NICU employees in failing to properly maintain and monitor the line, as Plaintiffs' experts concluded, or was an event that could occur absent anyone's negligence, as contended by Defendant's expert. In closing argument, Defendant's

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counsel admitted there was no dispute as to the duty Defendant owed to Plaintiffs. (75b-76b).

The issue most vigorously contested at trial was that of causation. Defendant's experts sought to persuade the jury that this episode of exsanguination had no impact upon Plaintiff Minor, and that his subsequent disabilities -- cerebral palsy in the form of spastic diplegia (paralysis) of his legs and mental retardation manifested by cognitive deficits -- were solely the consequence of his prematurity. Plaintiffs' experts explained that most children, 90 percent, born at twenty seven weeks gestation who receive proper neonatal care will develop normally (54b), and that Brandon's disabilities are related to the episode of massive blood loss following the dislodgement of the UAC. Both Dr. Modanlou and Dr. Crawford described how such blood loss caused shock and oxygen deprivation to the brain. Dr. Crawford testified that, "As a result of the ischemic insult or lack of blood flow to his brain, his brain became infarcted. He suffered the death of brain tissue, particularly in the area around the ventricles." (46b). But this was not the sole mechanism of Brandon's injury, for, as Dr. Lerer explained, when the Plasmanate was pushed to replace the massive blood loss, the sudden pressure triggered an intracranial bleed. (17b-22b). Dr. Crawford also explained that a change in blood flow and blood pressure can cause the little blood vessels to rupture and bleed. (47b). As a consequence of this episode Brandon has mental retardation and spastic diplegia of his legs. (44b-45b). He will not have the mental capacity for a high school education, will only be able to do routine work in sheltered workshops, and will need assisted residential care. (24b-25b). He will require special education, occupational therapy, physical therapy, and an increased degree of medical care. (45a-46a).

SOMMERS, SCHWARTZ, SILVER & SCHWARTZ, P.C.
ATTORNEYS AT LAW
2000 TOWN CENTER • SUITE 900 • SOUTHFIELD, MICHIGAN 48075 • (248) 355-0300

SOMMERS, SCHWARTZ, SILVER & SCHWARTZ, P.C.
ATTORNEYS AND COUNSELORS
2000 TOWN CENTER • SUITE 900 • SOUTHFIELD, MICHIGAN 48075 • (248) 355-0300

At the close of proofs the court went over the subject of jury instructions. Defendant offered its version of SJI 2d 30.01 which would have instructed the jury to confine its deliberations to evaluating the activities of a "neonatal nurse practitioner" in the same or similar communities. The trial court, on its own initiative, rejected Defendant's instruction and modified the standard jury instruction (86a-87a). The court instructed the jury that malpractice consisted of doing or failing to do that which a neonatal intensive care unit would do under the same or similar circumstances found to exist in this case and that "It is for you to decide, based upon the evidence, what the hospital neonatal intensive care unit, with the learning, judgment, or skill of its people, would do or would not do under the same or similar circumstances". (78b).

The case was submitted to the jury which returned a unanimous verdict for the Plaintiffs, awarding Plaintiffs damages of two million, four hundred thousand dollars.

III. PROCEEDINGS SUBSEQUENT TO TRIAL

Because of the lengthy post-trial odyssey of this case, much of it no longer relevant to the issues presented on appeal, we will here simply summarize the most significant events.

On June 13, 1994, the Circuit Court entered its Order of Judgment upon the jury's verdict. (127a).

On September 16, 1994, the Circuit Court granted Defendant's Motion for New Trial/Remittitur directing Plaintiffs to accept a remittitur to the amount of the mediation or be subject to a new trial. (129a)

On December 19, 1994 the Court of Appeals, upon Plaintiffs' application, entered an order vacating the Circuit Court's Order of Remittitur and remanding to the Circuit Court

with instructions that if the court deemed a remittitur appropriate that it detail its calculations in assessing the amount of remittitur. (131a)

On March 30, 1995, the Circuit Court on remand, in lieu of recalculating the remittitur, entered an order granting Judgment Notwithstanding the Verdict in favor of Defendant. (132a).

On November 22, 1996, the Court of Appeals issued its unpublished opinion reversing the Judgment Notwithstanding the Verdict. The Court of Appeals held that the evidence presented by Plaintiffs' expert witnesses supported the conclusion that negligent repositioning of the baby more likely than not caused the UAC to dislodge resulting in Plaintiff Minor's injuries. The court's opinion further states that "other issues" that had been briefed by Defendant in response to Plaintiffs' appeal were "precluded from review" because Defendant had not raised them by way of a cross-appeal. (136a-139a).

On January 14, 1997, the Court of Appeals entered its order denying Defendant's Motion for Rehearing, which had argued exclusively that the Court of Appeals had erred in concluding that a cross-appeal was required to obtain appellate review of these other issues. (140a)

On January 29, 1997, eschewing its opportunity to seek leave to appeal to this honorable court from the Court of Appeals denial of its Motion for Rehearing, Defendant instead filed a "Claim of Appeal" in the Court of Appeals from the June 13, 1994 Order of Judgment.

On June 11, 1997, the Court of Appeals dismissed Defendant's Claim of Appeal as untimely. (143a).

On July 21, 1997, the Circuit Court, over Plaintiffs' objections that it has no authority

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to do so, entered a second Order of Judgment exclusively for the purpose of allowing Defendant to "pursue its remedies" and appeal of right those issues the Court of Appeals had previously determined to be precluded from review. (145a).

On April 6, 1999, the Court of Appeals affirmed the original judgment entered in this case, agreeing with Plaintiffs that the Circuit Court had no authority to enter its second judgment July 21, 1997 and that the "law of the case" doctrine precluded consideration of the issues presented by Defendant. (153a-158a).

On May 16, 2000, in lieu of granting Defendant's Application for Leave to Appeal, this honorable Supreme Court entered an order remanding this matter to the Court of Appeals for consideration of the issues raised by Defendant because of the "unique circumstances" of this case. 462 Mich 859 (2000).

On October 27, 2000, the Court of Appeals on remand concluded that none of the issues raised by Defendant warranted setting aside the original judgment entered in this case, which it again affirmed. (167a-177a). Defendant's Application for Leave to Appeal from this decision was originally denied by this honorable court, 464 Mich 877 (2001), but upon rehearing was granted. 465 Mich 943 (2002).

Such additional facts as are relevant to the issues presented in Defendant's application are discussed further in the Argument portion of this brief.

SOMMERS, SCHWARTZ, SILVER & SCHWARTZ, P.C.
2000 TOWN CENTER • SUITE 900 • SOUTHFIELD, MICHIGAN 48075 • (248) 355-0300

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2000 TOWN CENTER • SUITE 900 • SOUTHFIELD, MICHIGAN 48075 • (248) 355-0300

ARGUMENT

I. THE CIRCUIT COURT CORRECTLY RULED THAT THE STANDARD OF CARE APPLICABLE TO NURSES STAFFING DEFENDANT'S LEVEL III NEONATAL INTENSIVE CARE UNIT WAS A NATIONAL STANDARD

The issues presented on appeal by Defendant Hurley Medical Center mainly revolve around the question of the proper standard of care applicable to nurses staffing a Level III neonatal intensive care unit of a major metropolitan hospital in Michigan. Defendant contends that a registered nurse providing care in such a facility is subject to the "same or similar communities" standard of care -- also known colloquially as the "locality rule" -- which has been applied traditionally to general practitioners in this state. Defendant maintains that the Circuit Court committed reversible error in allowing Plaintiffs' two expert witnesses, Dr. Houchang Modanlou, a neonatologist from California and Dr. Carolyn Crawford, a neonatologist from New Jersey, to testify regarding the standard of care for a nurse in Flint, Michigan without being required to show that they were familiar with the standard of care applicable to nurses in Flint, Michigan. The Circuit Court rejected Defendant's objection, stating, "... I consider that [neonatology] is a specialist area which means a nationwide standard." (58a). Defendant further argues that the Circuit Court's standard of care instruction to the jury was flawed because the court deleted the "same and similar communities" language of SJI 2d 30.01.

We contend, for reasons discussed in greater detail below, that both of these alleged errors were, at best, harmless error as, in this case, the appropriate standard of care that applied under the circumstances was not a contested issue. Defendant's own standard of care expert, Dr. Steven Donn, also a neonatologist, himself acknowledged that a national standard of care applied to NICUs and explained that his own testimony was

based upon general standards of care. (72b-74b). Defendant's own NICU nurse employee described her duties to monitor and maintain the integrity of the UAC exactly as this duty was set forth by Plaintiffs' experts. (32b). The issue in this case concerned whether this standard of care was breached, but there was no dispute as to what the standard of care required.

However, under the circumstances of this case, Plaintiffs submit that the Circuit Court was correct in finding that a nationwide or national standard of care applied to nurses providing care in Defendant Hospital's Level III NICU.

A. THE STANDARD OF CARE APPLICABLE TO A NURSE STAFFING A SPECIALIZED UNIT OF A HOSPITAL HAS NOT BEEN PREVIOUSLY DETERMINED BY THIS HONORABLE COURT

Defendant's arguments all begin with the premise that a nurse in Michigan is subject to the same "local" standard of care case law that has been applied to general practitioners. But, in fact, there exists no foundation, either in case law or in statutes, for this presumption. This is, in fact, a question of law that has not been satisfactorily resolved.

In order to place this issue in a proper perspective it is necessary to offer a historical review of the development of the standard of care doctrine in Michigan.

i. PELKY V. PALMER

Pelky v. Palmer, 109 Mich 561 (1896) is considered the seminal case in Michigan adopting the "same or similar communities" standard of care in medical malpractice cases. In actual fact, the trial court's instruction in that case had described the standard of care in reference to the specific "neighborhood" where defendant practiced. The Supreme Court found no error in this instruction under the specific circumstances of the case, but

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expressed reservations about this instruction as being too narrow, observing that the charge was inaccurate in being limited to the particular locality, but agreeing that the "character of the locality has an important bearing" on the degree of care required. 109 Mich, at 563. In the following years, the same or similar communities rule became the recognized standard of care applicable in medical malpractice cases brought against physicians and surgeons in this state, see e.g., Delahunt v. Finton, 244 Mich 226 (1928), Winchester v. Meads, 372 Mich 593 (1964). It was a rule flexible enough to allow experts from outside of Michigan to testify against physicians in this state, provided that the expert was familiar with the standard of care in the defendant's community or in a community similar to that of Defendant. Sampson v. Veenboer, 252 Mich 600 (1931); Bahr v. Harper Grace Hospital, 448 Mich 135 (1995). It is, of course, the measure of the standard of care that Defendant insists applied to the conduct of its NICU nurses in the present case. However, as will be shown, further developments have significantly modified this rule.

ii. NACCARATO V. GROB

The "same or similar communities" rule prevailed unmolested in this state for nearly a century -- a century notable for the rapid and far-reaching advances both in medical science and general technology. One of the major changes in the medical profession that occurred was the increased specialization of medical practice. While general practitioners continued to provide a significant service to the public, by 1970 an increasing number of physicians were engaging in medical specialties focusing upon a very specific and narrow range of medical issues. In Naccarato v. Grob, 384 Mich 248 (1970) a malpractice claim was brought against defendants who practiced a medical specialty, pediatrics, and the question that was presented on appeal was whether plaintiff's experts, pediatricians from

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Chicago and Los Angeles, were qualified to testify against defendants, pediatricians practicing in Detroit. The trial court had excluded the testimony of these experts on the basis that they did not know the standards of care prevailing in Detroit. This court reversed, and in so doing held that the locality rule was not appropriate where the defendant practitioners were specialists. This court explained that geographical considerations should have no bearing upon the knowledge and skills of a specialist:

> The reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices. Rather his knowledge is a specialty. He specializes so that he may keep abreast. Any other standard for a specialist would negate the fundamental expectations and purpose of a specialty. The standard of care for a specialist should be that of a reasonable specialist practicing medicine in the light of present day scientific knowledge. Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor the competence of an expert's testimony.
>
> 384 Mich, 253-4

This court had observed that "Whatever the considerations were that allowed the area practice to set the standard of care for the county general practitioners -- they are not relevant to a metropolitan specialist -- calling a specialist parochial or bucolic is hardly appropriate." 384 Mich, 253.

After Naccarato Michigan appeared to have two standards of care applicable in medical malpractice cases, a local standard of care that applied to general practitioners and a national (or non-geographic) "state-of-the-art" standard of care that applied to specialists.

iii. KAMBAS V. ST. JOSEPH

The next important decision of this court relevant to our present discussion is Kambas v. St. Joseph Mercy Hospital, 389 Mich 249 (1973). In Kambas a suit was

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brought against the defendant hospital alleging that a nurse of the hospital had negligently administered injections to plaintiff causing injuries. The suit was commenced more than two years, but less than three, after the alleged incident. The hospital asserted that the claim was barred by the two year statute of limitations applicable to medical malpractice actions. However, this court ruled that the three year general negligence statute of limitations applied. In reaching this result this court held that the term medical malpractice was restricted to claims against physicians and surgeons, to whom the term was applied at the common law, and did not extend to "nurses and other employees of defendant." 389 Mich, 256.

Kambas is a most significant decision showing that in the 1970s a cause of action for medical malpractice was deemed to be limited in applicability to claims brought against physicians and surgeons. The conduct of nurses was not governed by medical malpractice standards, but by general negligence standards.

iv. SIIRILA V. BARRIOS

Siirila v. Barrios, 398 Mich 576 (1976) is probably most notorious for what it failed to *accomplish. Defendant ws a general practitioner in Houghton, Michigan, against whom a* claim of malpractice was made relating to oxygen he ordered administered to a premature baby subsequently diagnosed with retrolental fibroplasia. The only witness offered against him was a pediatrician who admitted that he did not know what standard of care applied to a general practitioner. The verdict in favor of defendant was affirmed on appeal, wherein the majority held that the issue of what standard of care applied had not been preserved for review. But Justice Williams, in a well researched concurring opinion, explored the history of the locality rule and argued for its abandonment in favor of a

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national standard of care for all physicians. "We are persuaded" Justice Williams wrote, "that the factors we have reviewed -- rapid methods of transportation, easy means of communication, the efforts of the medical profession itself to disseminate the latest advances, as well as the obligation of any professional to keep abreast of such progress -- have rendered obsolete the reasons for maintaining greater emphasis on geography rather than on the state-of-the-art." 398 Mich, 625-6.

Hence, Justice Williams' concurrence pointed to a possible overthrow of the locality rule in Michigan that still applied to general practitioners. Whether this court would have taken that step in the future was a question forestalled by legislative action.

v. MCL 600.2912a

Within a year of the issuance of the Siirila decision the Legislature enacted MCL 600.2912a to codify the standard of care as it then existed. This statute, as enacted in 1997, provides:

> Sec. 2912a. (1) Subject to subsection (2), in an action alleging malpractice, the plaintiff has the burden of proving that in light of the state-of-the-art existing at the time of the alleged malpractice:
>
> (a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.
>
> (b) The defendant, if a specialist, failed to provide the recognized standard of care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

It should be observed that at the time this codification of Michigan's dual standard of care was enacted, the case law in Michigan still held, per Kambas, that medical

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malpractice applied only to claims brought against physicians and surgeons.

vi. WHITNEY V. DAY

The Court of Appeals decision in Whitney v. Day, 100 Mich App 707 (1980) is critical to understanding the issue on appeal. Defendant holds up Whitney as authority for applying the local standard of care to a nurse practitioner rather than the national standard of care that may apply to a specialist. Defendant can point out that the defendant nurse in Whitney was a nurse anesthetist, yet the Court of Appeals held that the locality standard applied, thus implying that even a nurse specialist is subject to the locality rule.

However, a closer and more careful reading of Whitney challenges Defendant's interpretation of this decision. The Court of Appeals was not asked, in Whitney, to decide between the local standard of care of general practitioners and the national standard of care of specialist. That issue was simply not before the court. Rather, that decision had to cope with the earlier Kambas ruling of this court holding that general negligence standards applied to nurses.

The trial court in Whitney had instructed the jury that nursing negligence "is defined as failure to apply that degree of skill and learning ... customarily applied ... in the same community." 100 Mich App, 710. On appeal Plaintiffs objected to this instruction, with its reference to community standards, as constituting a malpractice instruction, and thus at odds with the ruling of Kambas that nurses were liable in general negligence, not malpractice. Thus, the issue framed for the court was between giving a general negligence instruction and the one as given.[1] **Plaintiffs did not argue that the**

[1] *Perhaps the argument Plaintiffs should have made was that the instruction as given was* erroneous even as a medical malpractice instruction as it limited the standard of care to defendant's same community rather than to same or similar communities.

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defendant nurse anesthetist was subject to a national standard of care because of her specialization.

It was in this context that the Court of Appeals distinguished between the qualifications of a nurse anesthetist and an "ordinary nurse" to whom the Kambas rule might apply. Nurse anesthetists, the court noted, have expertise "in an area which is akin to medicine." Because they have responsibilities greater than those possessed by an ordinary nurse, the court concluded, it was not error to set forth a standard of care based upon standards "in the same community." 100 Mich, 711-12. As an afterthought, the court noted as well that following Kambas the medical malpractice statute of limitations was amended to include nurses as being subject to the two year statute. As a consequence, the court decided, malpractice actions are applicable to nurses. 100 Mich, 712.

We agree that Whitney stands as precedent for the proposition that in Michigan nurses are subject to being sued in medical malpractice rather than in general negligence. But we argue that, as a corollary to this conclusion, the standard of care that applies to a nurse sued for medical malpractice depends, as it does for physicians, on whether the nurse is a general practitioner or a specialist. Whitney, contrary to what is frequently represented, does not address that issue nor forbid applying a national standard of care to a nurse specialist.

vii. BAHR V. HARPER-GRACE

Another decision offered by Defendant as proof that a local standard of care applies to hospital nurses staffing a specialized unit of the hospital is Bahr v. Harper Grace Hospitals, 448 ich 136 (1995). But, in fact, this case did not discus the standard of care of

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hospital nurses, for the appeal concerned only the standard of care of hospital residents and interns and the qualifications of plaintiff's out-of-state expert to testify. Moreover, even with regard to such hospital interns and residents Bahr offers little insight as to the applicable standard of care, for, as this court observed at the commencement of its discussion, the parties agreed that the interns and residents were held to the local standard of care of non-specialists. 448 Mich, 138.

Thus, the question that is brought before this court here, whether a national standard of care should be applied to a neonatal intensive care nurse specialist, is one that has not been previously presented to this honorable court nor resolved by any prior precedent or statute.

B. A NATIONAL STANDARD OF CARE SHOULD APPLY TO A NURSE WHO ENGAGES IN A SPECIALIZED PRACTICE

The nurses who staffed Defendant's neonatal intensive care unit were not, by any stretching of this term, engaged in any sort of "general practice." They did not treat *children with measles, teenagers with scraped knees, nor adults with flu symptoms.* Narrowly and specifically they attended to the unique needs of newborns, assisting and carrying out the orders of neonatology specialists. Nurse Plamondon had 15 years of experience, her entire nursing career, working in Hurley's Level II NICU prior to the incident in question. (30b-31b). Nurse Krupp, who had three years experience, explained that to work in the NICU a nurse had a twelve-week orientation period, including two weeks of classes and ten weeks following a preceptor to learn how to take care of neonates. (63b-64b). Defendant's own expert, Dr. Donn, explained that a Level III NICU evolved as a subspecialty of the subspecialty of pediatrics, and is a unit that "can provide the most complex, state-of-the-art care." Babies will be transferred from Level I or Level II

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centers to a Level III **"for the types of care that are not normally provided in the community hospitals."** (66b-68b). (*emphasis added*)

We submit that it is folly to apply the local standard of care of "general practitioners" to specially trained and skilled nurses providing specialized care to newborns in facilities established to provide the most complex, state-of-the-art care, care not normally provided in community hospitals. There is simply no logic, reason, or precedent for so circumscribing the standard of care under these circumstances.

i. OTHER JURISDICTIONS

Before adopting MCL 600.2912a, Michigan appeared on its way towards abolishing the locality rule as the measure of a general practitioner's standard of care. A recent survey of sister states shows that nearly half have either never adopted, or have now abandoned, the "same and similar communities" limitation in assessing standard of care in medical malpractice cases.[2] More significantly, those states that have moved in the

[2] See e.g., Parker v. Collins, 605 So 2d 824 (Ala 1992); Capitol Hill Hospital v. Jones, 532 A 2d 89 (D.C. app 1987); Williams v. Ricks, 152 Ga App 555, 263 SE 2d 457 (1979); Advincula v. United Blood Services, 176 Ill 2d 1, 223 Ill Dec 1, 678 NE 2d 1009 (1996); Vergara v. Doan, 593 NE 2d 185 (Ind 1992); Speed v. State, 240 NW 2d 901 (Iowa 1976); Blair v. Eblen, 461 SW 2d 370 (KY 1970); Josselyn v. Dearborn, 143 Me 328, 62 A 2d 174 (1948); Shilkert v. Annapolis Emergency Hospital Assoc., 276 Md 187, 349 A 2d 245 (1975); Stepakoff v. Kantar, 393 Mass 836, 473 NE 2d 1131 (1985); Hall v. Hilburn, 466 So 2d 856 (1985); Ladish v. Gordon, 879 SW 2d 623 (Mo 1994); Velazquez v. Portadin, 163 NJ 677, 751 A 2d 102 (2000); Pharmaseal Lab Inc. v. Gaffe, 90 NM 753, 568 P 2d 589 (1977); Berdyck v. Shinde, 66 Ohio St 3d 573, 613 NE 2d 1014 (1993), Spencer v. Seikel, 742 P 2d 1126 (OK 1987); Sheeley v. Memorial Hospital, 710 A 2d 161 (RI 1998); King v. Williams, 276 SC 478, 279 SE 2d 618 (1981); Shamberger v. Behrens, 418 NW 2d 299 (SD 1988); Farrow v. Health Services Corp., 604 P 2d 474 (Utah 1979); Pederson v. Dumouchel, 72 Wash 2d 73, 431 P 2d 973 (1967); Paintiff v. Parkersberg, 176 W Va 469, 345 SE 2d 564 (1986); Sheir v. Freedman, 58 Wis 2d 269, 206 NW 2d 166 (1973); Raybal v. Bell, 778 P 2d 108 (Wyo 1989).

This list also does not include those states, like Michigan, that have abandoned the locality rule with respect to specialists. See e.g., Orcutt v. Miller, 95 Nev 408, 595 P 2d

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direction of applying a national standard of care have recognized that nurses, by reason of their own special training and skills, should be held to the same standards as physicians in assessing their malpractice. For example, in Berdyck v. Shinde, 66 Ohio St 3d 573, 613 NE 2d 1014 (1993) the court examined in detail the uniform training and education of registered nurses, and, after observing that nurses "are persons of superior skill and knowledge" who must employ that degree of care and skill that a nurse practitioner of ordinary care, skill, and diligence should employ in like circumstances, also acknowledged that "as with physicians, geographical considerations or circumstances do not control ... ." 613 NE 2d, 1022, 1023. In McMillian v. Durant, 312 SC 200, 439 SE 2d 829 (1993), defendant hospital argued that is pediatric nurses should be still subject to the local standard of care, after the state had abandoned that standard for physicians, but the court could find no justification for this distinction. "The old concerns for regional limits on training and lack of exposure to multi-regional practice for physicians is equally outdated for nurses" the court observed. 439 SE 2d, 832. The court found that the "evolution of the law appears to support the adoption of a national standard of care throughout the health system." Id. After reviewing case law from other jurisdictions applying the same rules of law to nurses as to physicians, the court noted, "Regardless of the geographic limit on the type of standard, many courts have recognized that nurses are health care professionals who should be subjected to the same standards as other health care providers." Accordingly, the court held that nurses in South Carolina were subject to the same national standards of care applied to physicians in that state. 439 SE 2d, 833.

1191 (1979); Aasheim v. Hamberger, 215 Mont 127, 695 P 2d 824 (1985); Jordan v. Boyner, 844 P 2d 644 (Colo 1993).

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ii. THE "LOCAL" STANDARD OF CARE SHOULD BE LIMITED TO TRUE GENERAL PRACTITIONERS

We make reference to this national trend of cases to urge consideration by this court of the view that except as to persons actually engaged in a general practice of medicine, where MCL 600.2912a(a)(a) legislatively mandates a local standard of care, a national standard of care should be applied to all health care professionals. The rationale that supported the adoption of a local standard of care two centuries ago no longer applies in the general practice of medicine. Even in the quarter century since Siirila was decided (and MCL 600.2912a enacted) there have been further advances in medical practice and technology altering the legal landscape of liability. A rule of law adopted to protect rural physicians practicing when the speediest form of communication was by post-rider seems hardly compatible with the standards of care applicable to physicians connected through the internet. When this court decided Siirila, the 22 boards of the American Board of Medical Specialties recognized 27 subspecialties. Today, there are 24 boards and the number of recognized subspecialties has increased to 88, more than triple the number in 1976. Today the role of "general practitioner" is most often filled by board certified specialists in internal medicine or family practice. And hospitals actively offer and promote a wide range of specialized departments, staffed by specially trained nurses, *specially trained technicians, and residents learning to specialize.*

The "same or similar community" rule codified in the statute may still have viability with respect to physicians and nurses engaged in a broad based, wide ranging medical practice, those who treat, as a primary health care provider, anyone and everyone who passes through the office door. But in the context of a modern metropolitan hospital, one that offers a variety of intensive care facilities, technical support and other specialized

services, a standard of care that is geographically biased has no validity. The standard of care did not elusively change every time someone other than a physician passed by Plaintiff Minor's bedside, switching whimsically back and forth between a local and a national standard depending upon whether it was Dr. Aranas or Nurse Plamondon who last looked at the baby. The NICU was established to provide Plaintiff Minor, continuously, with the highest state-of-the-art care, regardless of who happened to be in attendance at any particular point in time. Applying a national standard of care in this case was entirely appropriate to the circumstances.

iii. NEONATAL NURSES ARE SPECIALISTS

The case law and statutes of this state should be interpreted today as applying a non-geographical standard of care in medical malpractice cases except where the defendant is, in fact, a true general practitioner. We advocate the court adopting a realistic definition of general practitioner, and suggest that while MCL 600.2912a(1)(b) clearly states a non-geographical standard of care for "specialists", the dichotomy fixed by the statute does not inhibit the court from adopting this same non-geographical standard of care to health professionals across the board except as to those who are actually engaged in a general practice. We do not subscribe to the contention of Defendant, and ask this court to reject as insupportable in law and fact, that anyone who is not a board certified physician is necessarily a general practitioner. We submit that a nurse (and a resident or a medical technician) can be, and often is, a specialist, particularly when limiting his or her professional activities to serve exclusively in a specialized unit of a hospital. And where a nurse is a specialist, both Naccarato, supra, and MCL 600.2912a provide for a non-geographical standard of care.

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Defendant's NICU nurses in this case were working as part of a team of specialists providing state-of-the-art care. Plaintiffs' expert, Dr. Modanlou, testifies that "... it takes *certain expertise to manage babies like this, team expertise, not only physicians but* nurses, respiratory therapists to manage a baby like this." (13b). Defendant's own expert described this NICU as providing the most complex, state-of-the-art care. (67b). This phrase itself, used by Defendant's own expert, contains echos from Naccarato, supra, and MCL 600.2912a(1)(b), applying a national standard of care to specialists whose sources of knowledge are not limited to the geographic area but who practice medicine "in light of present day scientific knowledge." To paraphrase this court's ruling in Naccarato, supra, any other standard for Defendant's NICU staff "would negate the fundamental expectations and purpose" of the NICU.

Neonatal nursing is a specialty. As noted above, it required special training to become a nurse in Defendant's NICU. There exist at least two national organizations dedicated to enhancing and improving the specialty of neonatal nursing.[3] Under the standards promulgated by the Joint Commission on Accreditation on Hospitals, intensive care units of a hospital should be staffed by personnel who have undergone appropriate *orientation, training, and continuing education, and a planned, formal training program* must be implemented for registered nurses and support staff.[4] To ignore the fact of specialization by the nurses staffing Defendant's NICU is to ignore the stark reality of the way medical care is actually provided today within all major medical facilities.

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[3] Association of Women's Health, Obstetrics, and Neonatal Nurses and National Association of Neonatal Nurses. Both publish journals relating to neonatal nursing and have helpful internet sites.

[4] 1990 Joint Commission Accreditation Manual for Hospitals, SP 3, p. 246.

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If none of this is persuasive, consider this irony. It is Defendant's contention that all registered nurses are "general practitioners" subject to a local standard of care. According to this skein of logic, a registered nurse who worked all her professional career in a nursing home in Flint, attending only to elderly patients, would be qualified to testify to the standard of care applicable to Defendant's nurses in this case, but neonatologists from outside of Michigan, who daily work beside nurses attending infants in hospital NICUs, would not. Clearly, a rule of law that lends itself to such an absurd conclusion, if operative, is one that ought to be changed.[5]

As a last comment on this point it may be worthy to note that in proposing a standard of care instruction to the court, Defendant requested one that would instruct the jury that the standard of care was that of a "*neonatal* nurse practitioner of ordinary learning or judgment or skill in this community or a similar one." (*emphasis added*). (87a). Even Defendant could not elude the fact that the nurses whose conduct was at issue were not just simply nurses, but neonatal nurses. Defendant sought to confuse the jury with a bizarre hybrid instruction, one giving Defendant the benefit of dual restrictions, first limiting the standard of care to only what neonatal nurses would do as specialists, rather than nurses in general, and then further, and inconsistently, limiting that specialist standard to the local community practice.

Neonatal nurses are not general practitioners, and in providing care to newborns in

[5] We are not unmindful of the significant changes the Legislature has made with respect to the reception of expert testimony in medical malpractice cases since the 1994 trial of this action. Were this case tried under present law, both parties would have to elicit standard of care testimony from a nurse, rather than from physicians who worked with nurses. MCL 600.2169. But would it not still make more sense to receive such standard of care testimony from an NICU nurse practicing in Los Angeles or Chicago than from one

a modern hospital it is altogether proper that such nurses be held to a nationwide standard of care, the standard of care expected of such nurses in any NICU throughout the country. Not a single witness in this case indicated that it should be otherwise. No statute nor precedent of this state compels a different conclusion, and certainly not the conclusion that such NICU nurses are subject to a more limited and unwarranted local standard of care.

Thus, the Circuit Court was correct in ruling throughout the trial that the proper standard of care was not the "same or similar communities" standard but a general or national standard of care. It follows from this that the court's rulings on the admissibility of expert testimony and its instruction to the jury were likewise correct under the circumstances of this case.

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working at a nursing home in Flint, whose only "qualification" for offering testimony is the mere accident of geography?

II. THE CIRCUIT COURT CORRECTLY EXERCISED ITS DISCRETION IN ADMITTING THE TESTIMONY OF PLAINTIFFS' EXPERTS

The decision to allow the introduction of expert opinion testimony is left to the discretion of the trial court and will not be reversed absent an abuse of discretion. Cook v. Detroit, 125 Mich App 724 (1983). An error in the admission or exclusion of evidence is not grounds for granting a new trial or setting aside a verdict or judgment unless refusal to do so would be inconsistent with substantial justice. MCR 2.613(A).

Defendant on appeal objects to the trial court's ruling in this case that a "general" or "national" standard of care applied because this ruling allowed Plaintiffs to present the expert opinion testimony of Dr. Houchang Modanlou and Dr. Carolyn Crawford. Defendant argues that had the trial court adhered to a "local" standard of care the trial court would have found these witnesses not qualified to testify in this case. We disagree.

As indicated in the previous section of this brief, the trial court's application of a national standard of care was appropriate under the circumstances of this case. Defendant Hospital and its employees were simply not engaged in a general practice when attending to Plaintiff Minor in a neonatal intensive care unit. Hence, familiarity of the standard of care practiced in "the same or similar communities" should not have been required of the standard of care experts presented in this case. All that was required was their familiarity with the standards of care of neonatal nurses working in NICUs nationwide.

Further, even if the "same and similar communities" standard remained the measure of Defendant's duty towards Plaintiffs, the court would not have erred in permitting these experts to testify. First, the experts' own backgrounds demonstrated sufficient familiarity with the standards in "similar" communities to permit them to testify.

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Further, the evidence presented was persuasive that the matters at issue were subject to a universal standard that applied in every community, including Defendant's. This was evidenced by the fact that the duty of care described by Plaintiffs' experts as being applicable in this case was identical to the duty as described by Defendant's own nurse. Defendant presented no evidence of any parochial standard of care that differed from that described by Plaintiffs' experts. Because this standard of care was undisputed and unchallenged, whatever error was committed by the court in allowing Plaintiffs' experts to testify was harmless error having no affect upon the outcome of this case.

A. BACKGROUND

Plaintiffs' experts presented to the court with outstanding professional credentials.

Dr. Houchang Modanlou is a board certified neonatologist who worked on staff at Long Beach Memorial Medical Center. (3b). He was board certified in 1975. (2b). He is also an Associate Professor of Pediatrics at the University of California Irvine. (3b). In addition, he is the Director of the Neonatal/Perinatology Fellowship Program. (3b). He belongs to numerous professional societies in pediatrics (4b), has authored or co-authored over 120 abstracts, 50 to 60 papers in his field, and is a journal reviewer. (4b-5b). In addition, he provides patient care to high risk newborns on a day to day basis, supervising medical students, nurses, residents, and fellows. (5b). He indicated that his own familiarity with the standard of care is based upon his reading, and his interaction with colleagues across the country. (6b). He testified that he was familiar with the standard of care in NICUs relating to the placement of UACs with respect to both physicians and nurses. (8b).

Dr. Carolyn Crawford is board certified in neonatal/perinatal medicine and licensed

to practice in Pennsylvania and New Jersey. (41b). She spends approximately 40 hours a week working in an NICU while also being on-call to serve at three other hospitals in the community. (41b). She has been a director of a neonatal unit, developed a fellowship program for training fellows in neonatology, and served six years as Medical Director of the Southern New Jersey Perinatal Cooperative setting up the protocols and procedures for newborn care at 15 hospitals. Dr. Crawford has observed the performance of NICU nurses and assessed the adequacy of their performance. (43b). She personally feels that there is a national standard of care for both physicians and nurses in NICUs in the sense that the care rendered in any one NICU should be equivalent to that provided in any other NICU. (42b-43b).

Defendant Hurley Hospital placed Brandon in its Level III NICU. This is the highest level NICU, one that, according to Defendant's own standard of care expert, provides the type of care not normally provided at community hospitals (67b), the "most complex, state-of-the-art care". (67b). It is staffed by neonatology specialists -- Dr. Nolan who inserted the UAC into Brandon is board certified in pediatrics, pediatric intensive care and neonatal intensive care (61b-62b), and his partner, Dr. Aranas, who ordered the adjustment of the UAC, is a neonatologist. (61b-62b). The nurses staffing the NICU were also specially trained and experienced in treating newborns. Edith Krupp, who executed Dr. Aranas' order and pulled the UAC out 2 centimeters, had worked exclusively in this NICU since 1987 after receiving twelve weeks of orientation learning to take care of neonates. (63b-64b). Nurse Plamondon had 15 years of experience exclusively working in Hurley's NICU before attending to Brandon. (30b-31b).

In preparing this case for trial Plaintiffs had no anticipation that there would be any

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difficulty in qualifying Drs. Modanlou and Crawford as experts in this case. Given the nature of Defendant's NICU and its staffing and the credentials and experience of Plaintiffs' experts, there appeared to be no obstacle to their testifying. Both of these experts worked in NICUs equivalent to Defendant's in the level of care provided and worked with nurses, residents, and fellows in such NICUs so as to be familiar not only with the standard of care of neonatologists but of the standard of care of these other NICU staff assistants.

B. DEFENDANT'S OBJECTIONS

During the *de bene esse* deposition of Dr. Modanlou, Defendant's counsel conducted a *voir dire* of this witness which focused upon the doctor's unfamiliarity with Hurley Hospital's own standards. Dr. Modanlou explained that while he did not know what specifically went on at Hurley Hospital in Flint, he did understand, based upon his familiarity with the standards of practice in NICUs throughout the country, what the standard of practice should have been in Defendant Hospital. "At Hurley I am not familiar, but my expectation is since the nurse is the main person on the bedside, more consistently, my understanding is in every unit in the United States the nurse is responsible to make sure if an umbilical arterial catheter is in place, is maintained properly, and stay in place properly." (10b).

When Plaintiffs offered to place Dr. Modanlou's *de bene esse* deposition into evidence, Defendant objected on the basis that this witness was not aware of the procedures and protocols of nurses in Michigan regarding UACs. (27a).

Defendant's own *voir dire* of Dr. Modanlou and the stated objection demonstrated a misunderstanding of Michigan law. As discussed in the previous section of this brief, the

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locality rule in this state does not require the expert to be familiar with the standard of care practiced in Defendant's own community, nor even as practiced in Michigan, but allows such testimony from an expert familiar with the standards of practice in similar communities.

Defendant's objections were supported at trial by citation to the Court of Appeals decision in Bahr v. Harper Grace Hospital, 198 Mich App 31 (1993). The Court of Appeals had held in that case that a witness from Pennsylvania was not qualified to testify as to the standard of care that applied to residents and interns at a hospital in Detroit, which the parties agreed to be a local standard of care. The trial court critically read this Court of Appeals case and found it did not apply. (30a-31a). In so doing it anticipated this court's own reversal of that decision.

C. A NATIONAL STANDARD OF CARE APPLIED

If this honorable court agrees that the Circuit Court was correct in applying a national standard of care in this case, for the reasons detailed in the previous argument, then clearly the court committed no error in allowing Plaintiffs' eminently qualified experts to testify and all further discussion of this issue is moot. What follows is relevant only if this court agrees with Defendant that a geographically biased standard of care applies to neonatal nurses working in a neonatal intensive care unit.

D. PLAINTIFFS' EXPERTS WERE QUALIFIED EVEN UNDER THE LOCALITY STANDARD

Throughout these post-trial proceedings and appeals Defendant has referred to Bahr, supra, as the touchstone against which the rulings of the trial court should be measured. We agree. This case is in many ways identical to Bahr, which ultimately held that the trial court had correctly exercised its discretion in permitting an out of state expert

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to give testimony touching upon a local standard of care.

Here, as in Bahr, the trial court exercised its discretion in permitting an out of state expert to offer opinion testimony that employees of the defendant hospital had breached the standard of care. Here, as in Bahr, the Defendant argued that a local standard of care applied and on appeal criticized the trial court for having allowed the expert to testify without any foundation that the expert was familiar with the local standard of care This case also resembles Bahr in that the defense counsel in Bahr did not clearly explain to the trial court the nature of the deficiencies of the expert's qualifications nor provide any evidence that the standard of care for hospital employees in the community where defendant practiced was different from those standards in the community where the expert practiced. In our present case Defendant simply objected that Dr. Modanlou was unfamiliar with the standards of Hurley Hospital, made no inquiries as to his familiarity with the standards in similar communities, and also presented no evidence of any difference between these standards (which, in fact, were subsequently shown by the testimony of Defendant's own employees to be the same).

The Court of Appeals had ruled in favor of Defendant in Bahr, and it was this Court of Appeals decision that Defendant relied upon in making its objection to Plaintiffs' experts at trial. This honorable court reversed that decision, upholding the court's discretion to allow such testimony when satisfied that the expert has sufficient familiarity with the standards of care involved in the case on the basis of the expert's own education and practice. 448 Mich, at 141.

We have surveyed the credentials of Plaintiffs' experts above to show that even if the trial court had agreed with Defendant's "locality" rule objection (and had that objection

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been properly articulated as a same or similar community rule), these experts would have been qualified under that standard. The fact that these experts had never practiced in Michigan nor at Hurley Hospital -- the point of Defendant's criticism at trial -- is, of course, entirely irrelevant. Both of these experts had active experience in working in NICUs similar to the Level III NICU at Hurley, observing and monitoring the activities of physicians, residents, fellows, and nurses performing their duties in these special care units. Hurley Hospital is itself a major metropolitan hospital located in a moderately sized urban area. The hospitals where Plaintiffs' experts practice, in Long Beach, California and Atlantic City, New Jersey, have similar demographics. If the trial court did apply the same or similar community rule to this case, it would have been error for the court not to find Plaintiffs' experts to be qualified under this standard. See e.g., Turbin v. Graesser, 214 Mich App 215 (1995).

E. THE LOCAL STANDARD OF CARE AND THE NATIONAL STANDARD OF CARE WERE THE SAME

Michigan law supports a modest modification of the locality rule which recognizes that where the evidence shows medical practice to be common across the country, it necessarily follows that it is a standard of practice in the same or similar communities as that of the defendant.

In LeBlanc v. Lentini, 82 Mich App 4 (1978) it was recognized that even where a local standard of care may apply to a practitioner, if it is established through testimony that the local standard of practice is uniform throughout the country, an expert familiar with that uniform standard may testify. In Mazey v. Adams, 191 Mich App 328 (1991) the Court of Appeals upheld a ruling that allowed a cardiologist from California to testify against an osteopathic general practitioner when he testified that the standard of care involved was

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national in scope and "this was not contradicted by any evidence at trial". Hence, even where a "national" standard of care may not be appropriate to a particular defendant, a "nationwide" uniform standard of care may apply where the evidence indicates that every community applies the same standard, and thus embraces the "same or similar community" standard.

In the present case there was no evidence presented that some local or parochial standard applied in Flint, Michigan or other similar communities in which it is deemed an acceptable practice for Level III NICU nurses to allow UACs to become dislodged. Rather, the testimony presented was that it was the uniform standard of practice nationwide, for NICU nurses to be responsible for monitoring and maintaining the integrity of such UACs. As already mentioned above, Nurse Plamondon herself acknowledged that this was her responsibility at Hurley Hospital. (32b). In the absence of any evidence that this standard of care was subject to local variations or was in any way different in Flint, Michigan that it was elsewhere in the nation, the trial court did not err in admitting the testimony of Plaintiffs' experts over Defendant's objections. See Bahr, supra, 448 Mich, at 142, n. 17.

F. HARMLESS ERROR

If the court below erred in admitting the testimony of Plaintiffs' standard of care experts under a "national" standard of care when a "same or similar community" standard applied, such error was clearly harmless under the circumstances of this case.

This was a case where the standard of care was simply not disputed. Plaintiffs could have established the standard of care in this case through the testimony of Defendant's own employees. Indeed, as it turned out this actually occurred. All Dr.

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Modanlou offered as standard of care testimony concerning Defendant's NICU nurses was that it was their responsibility to monitor and maintain the integrity of a UAC line. (10b, 11b). Defendant's own employee, Nurse Plamondon, provided identical testimony. (32b). No witness disputed the scope of her responsibility towards the UAC. The only truly disputed issue in this case with respect to Nurse Plamondon was whether she had breached this standard in negligently allowing the UAC to become dislodged and/or failing to observe this dislodgment while Brandon was under her care. And this was a conclusion the jury could draw on its own based upon the facts and inferences in evidence.

Michigan has long recognized that a plaintiff in a medical malpractice suit can establish the standard of care through the testimony of defendants and defense witnesses. Rice v. Jaskolski, 412 Mich 206, 211-12 (1981); Niemi v. Upper peninsula Orthopedics Assoc., 173 Mich App 326, 331 (1988). Moreover, the issue of breach of the standard of care does not have to be established by expert testimony, but can be properly left to the jury to decide. Baldwin v. Williams, 104 Mich App 735, 739-40 (1981); Niemi, supra. Even denying Plaintiffs the benefit of their experts' testimony on the standard of care in this case, a *prima facie* case of malpractice was established through the standard of care testimony of Defendant's own employees, and the unchallenged causation testimony, sufficient to allow the jury's verdict to stand.

Again, standard of care was a non-issue in this case. Defendant's objections notwithstanding, there simply was no controversy over the duty Defendant's employees owed to Plaintiffs. There was no "local" standard of practice absolving Nurse Plamondon of her responsibility to maintain the integrity of the UAC line while Brandon was in her

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care. Her own testimony set forth the applicable standard of care in this case, and as the testimony of Plaintiffs' experts merely stated identical standards of care, Defendant could not have been harmed by the admission of their standard of care testimony.

For all these reasons, the decision of the Circuit Court to allow Plaintiffs' experts to present standard of care testimony in this case should be affirmed.

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III. THE MODIFIED VERSION OF SJI 2d 30.01 BY WHICH THE CIRCUIT COURT INSTRUCTED THE JURY WAS APPROPRIATE TO THE CIRCUMSTANCES OF THIS CASE AND ADEQUATELY AND FAIRLY PRESENTED THE ISSUES TO THE JURY

A. STANDARD OF REVIEW

Michigan follows a "harmless error" standard for determining whether instructional error by the trial court warrants a reversal of the jury verdict. Johnson v. Corbet, 423 Mich 304, 326 (1985).

Furthermore, it has long been recognized that a failure to object to an instruction and the failure to preserve an issue on appeal generally precludes appellate review. Continental Studios Inc. v. American Auto Ins. Co., 340 Mich 6, 13 (1954); McKinney v. Anderson, 373 Mich 414 (1964); MCR 2.516 (C). Absent an objection the appellate court will only reverse a verdict due to an instructional error to prevent a manifest injustice -- that is where the instructional defect is of such magnitude as to constitute plain error and where it pertains to a basic and controlling issue in the case. Mina v. General Star Indemnity Co., 218 Mich App 678 (1996) rev'd in part, 455 Mich 866 (1997).

The determination whether a jury instruction is applicable and accurately states the law is within the discretion of the trial court. Reversal is not required if, on balance, the theories and the applicable law were adequately and fairly presented to the jury. A verdict should not be reversed as a result of an erroneous charge unless the failure to do so would be inconsistent with substantial justice. Murdock v. Higgins, 454 Mich 46, 60 (1997); Szymanski v. Brown, 221 Mich App 423, 430 (1997). Instructions are to be reviewed in their entirety, rather than extracted piecemeal to establish error in certain portions. Nabozny v. Pioneer State Ins. Co., 233 Mich App 206, 217 (1998); Wiegerink v. Mitts & Merrill, 182 Mich App 546, 548 (1990).

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B. THE STANDARD OF CARE INSTRUCTION AND DEFENDANT'S OBJECTIONS

The trial court made its own modification of SJI 30.01, rejecting the proposed instructions proffered by the parties. The court's instruction to the jury defining *malpractice was as follows:*[6]

> When I use the words professional negligence or malpractice with respect to Defendant's conduct, I mean the failure to do something which a hospital neonatal intensive care unit would do or the doing of something which a hospital neonatal intensive care unit would not do under the same or similar circumstances you find to exist in this case.
>
> It is for you to decide, based upon the evidence, what the hospital neonatal intensive care unit with the learning, judgment, or skill of its people would do or would not do under the same or similar circumstances.

(78b)

When the trial court announced that it would present this wording to the jury, Defendant made two objections. Defendant objected to the omission of the words "in this community or a similar one" arguing these words were required because a local standard of care applied to nurses. Defense counsel also protested, "I believe that this case does really focus on Plamondon and the nurse's responsibility with regard to this UAC line coming out, and therefore I don't believe its as broad as the whole unit." (87a). These were the only objections made by Defendant to the giving of these instructions at trial.

On appeal Defendant argues that this instruction was erroneous and prejudicial. Defendant continues to protest that a local standard of care applies and that the instruction

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[6] Although listed in its Table of Contents, Defendant-Appellant's Appendix does not actually contain the trial court's charge to the jury as required by MCR 7.307(A)(1)(6). Instead it contains Defendant's own requests for instructions. See Defendant's Appendix, pp. 88a-125a.

was flawed in omitting the qualifying "same and similar communities" language. Defendant Hospital exponentially expands upon the objection to the instruction's reference to the hospital's neonatal intensive care unit, claiming that this error necessarily confused the jury, overlooked the different standards of care applicable to the different people working in the unit, and constitutes a fundamental error of law. And Defendant raises an entirely new objection for the first time in this appeal, asserting additional error in the trial court's omission of the adjective "ordinary" when describing the skill and judgment of the persons employed in Defendants NICU.

Plaintiffs submit that this modified jury instruction properly served its purpose in fairly and adequately presenting the issues to the jury, that it was not erroneous under the circumstances of this case, and that whatever errors were committed were harmless given that the duty Defendant owed towards Plaintiff Minor was not a disputed issue.

C. OMITTING THE "SAME OR SIMILAR COMMUNITIES" LANGUAGE WAS NOT ERROR

For reasons already explored in some depth under the prior two arguments, the trial court did not err in omitting the "same or similar communities" language from this instruction. As previously mentioned, the instruction Defendant itself requested (87a) acknowledged that the proper standard of care was that applicable specifically to neonatal nurses, not to nurses in general, and such neonatal nurses, we submit, are specialists to whom a national, rather than a local, standard of care should apply.

Furthermore, at the risk of repeating ourselves, standard of care was never a contested issue in this case. Defendant's own counsel admitted as much in closing argument, telling the jury that of the four elements of a malpractice case – duty, breach, proximate cause, and damages -- only the second and third, breach and proximate

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causation, were "hotly in dispute in this case". (75b-77b). The actual duty owed by Defendant to Plaintiff Minor, measured by whatever standard of care we choose, was undisputed.

Every witness who testified in this case concerning the operation of neonatal intensive care units agreed that it was the responsibility of an NICU nurse to monitor and maintain the integrity of the UAC. There simply is no "local" versus "national" standard of care deviation from this duty. Everywhere -- at Hurley Hospital in Flint, at University of Michigan Hospital in Ann Arbor, at Long Beach Memorial Medical Center in California, at the hospitals served by the Southern New Jersey Perinatal Cooperative, and at all NICUs throughout the country -- this is the uniform obligation of an NICU nurse. We cannot get more "local" than Nurse Plamondon herself, who testified:

Q: And is it the responsibility of a nurse to maintain and monitor UACs?

A: Yes.

(32b)

Through six years of post-trial motions and appeals Defendant has failed to answer Plaintiffs repeated challenge, what difference did this instruction make? Defendant claims that this instruction mislead the jury regarding the standard of care, because the jury *should have been told to evaluate Nurse Plamondon's actions in accordance with a "local"* standard of care. But what difference did this omission make? **There is absolutely nothing in this record, not a single sentence of a single witness, that indicates that Nurse Plamondon's duties under any such local standard of care was a jot different from what they would have been under any alternative standard of care.** Her job as an NICU nurse at Hurley Hospital was exactly the same as it would have been in any other

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NICU in this country -- to monitor and maintain the UAC. The instruction the court gave in no way misled the jury about the duty Defendant Hospital owed to Plaintiffs.

If Defendant had presented evidence that at Hurley Hospital in Flint or in some similar communities the standard of care does not require an NICU nurse to monitor or maintain the UAC then Defendant might have cause to complain about this instruction. If Defendant had presented testimony that it is within the accepted standard of care at Hurley Hospital for an NICU nurse to cause a UAC to be dislodged while manipulating the baby and to fail to observe whether her manipulation of the baby caused the UAC to be dislodged (which is, of course, absurd), Defendant would have a valid point to make in criticizing an instruction that failed to take into account such local eccentricities of the standard of care. But, the fact is, no such evidence was ever introduced nor even proffered by Defendant. Indeed, Defendant's own standard of care expert did not confine his opinion to the standards in the same or similar communities, but admitted that his own testimony of what was required in Defendant's NICU was based upon general neonatology standards. (74b).

No evidence was presented in the course of this trial suggesting that the neonatal nurses in Defendant's NICU was practicing some local variant of the standard of care that differed from the standards followed by neonatal nurses working in NICUs throughout the nation. Consequently, even if it was error for the court to omit this geographical limitation defining malpractice for the jury -- and for the reasons stated in our previous arguments it was not -- such omission would constitute only harmless error in light of the facts of this case.

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D. REFERENCE TO DEFENDANT'S NEONATAL INTENSIVE CARE UNIT IN THE INSTRUCTION WAS APPROPRIATE UNDER THE CIRCUMSTANCES OF THIS CASE

In Johnson v. Corbet, supra, this court had observed that the trial court has the discretion to apply standard jury instructions "not in an abstract or theoretical sense, but in the context of the 'personality' of the particular case on trial, and with due regard for the adversaries' theories." 423 Mich, at 327. See also, Tobin v. Providence Hospital, 244 Mich App 626 (2001).

In the present case the trial court rejected Defendant's requested instruction limiting consideration of Defendant's liability to the conduct of a single nurse, and crafted instead an instruction that defined standard of care in the context of Defendant's neonatal intensive care unit. No doubt in doing so the court was recalling the testimony of Plaintiffs' experts which indicated that regardless of who was taking care of Brandon in Defendant's NICU, the UAC should not have come out:

A: The biggest problem is UAC came out and the baby bled. That is the major problem with this case. It should not have happened.

Q: Is it a breach of the standard of care for that to happen?

A: That is my understanding.

(11b)

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Q: So you would agree that in this particular case it is possible for the UAC line to come out even in the face of appropriate precautions against them in terms of what is on the chart?

A: No. If proper precaution has been taken of maintaining the catheter in place, it should not come out. Doesn't matter who cares for the

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child. (*emphasis added*)

(12b)

***

Q: ... I asked you, isn't it true that you're critical of every physician and every nurse that had anything to do with regard to the UAC placement until the line was discovered to be out at 4:20 on February the 10th?

A: If they were involved in the line maintenance or involved in the line adjustment and it wasn't done properly, yes, I would be critical.

(59b)

The circumstantial evidence in this case strongly implicated Nurse Plamondon as having dislodged the UAC when she repositioned the baby at 4:00 p.m., although she denied doing so. (16b, 56b). While the focus of argument concerned Nurse Plamondon[7] the testimony of Plaintiffs' experts made if clear that regardless of who attended to this baby in Defendant's NICU, the UAC should not have come out, and because it did, it is somebody's fault. (12b, 14b, 50b, 55b). If not Nurse Plamondon, then "somebody was responsible for the line to come out." (16b).

Defendant's principle objection, citing Tobin, supra, is that by stating the standard of

[7] Contrary to what has been frequently misstated by Defendant, Plaintiffs never stipulated at any time that this case only involved claims against Nurse Plamondon. The only concession made by Plaintiffs' counsel was that Plaintiffs would not pursue any claims based upon the ventilator settings used in treating Brandon. (35a).

In fact, Plaintiffs' experts also criticized Nurse Krupp for not having the UAC resutured after pulling it out two centimeters (59b), criticized the respiratory therapist for not assisting Nurse Plamondon after discovering the exsanguination (60b), and questioned the alleged actions of Dr. Villegas who, according to Nurse Plamondon, was in the NICU but never came over to look at Brandon. (15b, 52b-53b). No neonatologist did for twenty minutes after the dislodgement was discovered.

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care in terms of the hospital's "unit" the court confused the jury, especially because different standards of care applied in that unit depending upon who happened to be attending to the baby at any particular time. Our response to this contention has already been addressed in some detail above. Defendant's NICU was designed to provide Brandon with continuous, around-the-clock, state-of-the-art care, superior to that provided in a community hospital. That standard of care did not change according to the chance of who happened to be standing by the baby's crib at a particular moment. The learning, judgment, and skill of all the people staffing Defendant's NICU stood equal to the learning, judgment, and skill of people staffing any other NICU throughout the country. If this court agrees that a neonatal nurse is subject to a non-geographical standard of care, most of Defendant's criticism of this instruction is defused.

It has been suggested that this instruction wrongfully "depersonalized" Plaintiffs' claim of malpractice against Defendant, but this claim makes no sense. First, this was not stated as a basis for Defendant's objection to this instruction at trial. Next, it is clear that the instruction read as a whole related the standard of care to what the people of Defendant's NICU did or did not do. As the Court of Appeals noted below, the jury understood that the court was not referring to negligence of a building, to the "bricks and mortar" of Defendant's NICU, but to the care rendered by Defendant's employees. The jury was told by the trial court to decide what an NICU "with the learning, judgment, or skill **of its people** would do or would not do" under the circumstances. Finally, Defendant in this case was itself the hospital, not Nurse Plamondon or any other hospital employee. The jury already understood that Plaintiffs' claim was one made against an institution, not an individual, and stating the standard of care in terms relating that standard to a unit of

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that institution would not have deflected the jury from its analysis of whether Defendant should be held responsible for the negligence of the people staffing that unit.

In the circumstances of this case this instruction was appropriate. In a different case, involving different facts, it might not be, but trial courts have the discretion to modify standard jury instructions to fit the personality of the case being tried. In this case, defining malpractice for the jury in terms of what an NICU should do or not do under the *circumstances fit the evidence presented and was without prejudice* to Defendant. Again, we remind this honorable court that standard of care was not a disputed issue -- that a UAC should be monitored and maintained in an NICU to avoid its dislodgment causing a massive bleed was a premise everyone agreed upon. The controverted issue was whether such dislodgment could occur even if every precaution was taken in the NICU, as Defendant contended, or whether, as Plaintiffs' experts testified, this could only occur if someone was negligent.[8] Stating the duty of Defendant in terms of its neonatal intensive care unit had absolutely no impact upon how this disputed issue was assessed by the jury. Like the omission of the "same or similar communities" qualification above, the court's statement of the standard of care in terms of Defendant Hospital's unit was, if error, no more than harmless error under the facts of this case.

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[8] Defendant, through Dr. Donn, offered alternative explanations for the line becoming dislodged -- the securing tape failed due to warming lights drying it, or it got wet from the baby's own moisture, or the baby jerked the line out by its active movements. (69b-71b). All of these explanations were based entirely on speculation for there were no facts in the record showing that the tape itself came loose or that this 900 gram baby on sedation was active.

These alternative scenarios, furthermore, do not exonerate Defendant, but are significant in pointing out that if Nurse Plamondon's repositioning of the baby did not cause the dislodgement, then others were liable for failing to inspect the condition of the tape or *failing to secure the line consistent with the baby's level of activity.*

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E. THE TRIAL COURT'S OMISSION OF THE WORD "ORDINARY" IS NOT AN ERROR OF SUFFICIENT MAGNITUDE TO REQUIRE REVERSAL WHERE DEFENDANT MADE NO OBJECTION AT TRIAL AND NEVER RAISED THIS IS ISSUE IN SIX YEARS OF APPEALS

In this present appeal Defendant also criticizes the trial court's instruction for omitting the word "ordinary" from the charge when referring to the "learning, judgment, and skill" of the people of Defendant's NICU.

Defendant did not make an objection to this omission at trial. Nor did Defendant present this as an issue on appeal in any of the several appeals that Defendant has pursued in this case. This issue was raised for the first and only time in the dissenting opinion in the last of the Court of Appeals decisions on appeal. From that platform, Defendant now presents this issue for this court's consideration.

The fact that Defendant made no objection to this omitted word at trial and never represented this omission as being error in any of its post-judgment motions nor throughout six years of appeals is itself some measure of the insignificance of this omission. Quite simply, the omission was not noticed, was entirely unremarkable. Only a detailed scouring of the record disclosed that this word, ordinary, was inadvertently left out when the Circuit Court read its own modified version of SJI 30.01 to the jury.

Yet, obviously, had Defendant objected to this oversight and brought it to the trial court's attention, it would have been an omission easily curable. Defendant's failure to object means that this omission cannot be viewed as significant unless shown to be one causing manifest injustice. Defendant must show this defect to be of such magnitude as to constitute plain error pertaining to a basic and controlling issue in this case. Mina, supra.

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That this omission did not pertain to a basic and controlling issue of this case is manifest in all the arguments we have heretofore presented. The instruction as a whole provided straightforward definitions of the duty owed by Defendant, a duty and a standard of care that essentially was not disputed. The jury did not need the word "ordinary" to tell them that the learning, skill, and judgment of the people of Defendant's NICU required them to maintain the security of a UAC line. That duty was unchallenged and uncontroverted. The omission of the word "ordinary" from this instruction was entirely without prejudice to Defendant.

Where a word is omitted from a jury instruction but no prejudice results therefrom, such omission is not grounds for reversal. Cody v. Marcel Electric Co., 71 Mich App 714, 720-21 (1976); Van Every v. Southeaster Michigan Transportation Authority, 142 Mich App 256, 259-60 (1985). Notably, the featured case cited by Defendant on this issue, Murdock v. Higgins, 454 Mich 46 (1997) does not concern itself with the omission of a single word from a standard jury instruction, but the giving of an entire instruction having no relationship to the proper issues of the case. (The trial court instructed the jury on the Child Protection Law even though defendant was not a person subject to that law).

Here it cannot be said that the trial court's omission of the word "ordinary" in any way altered the meaning of the instruction as to cause prejudice to Defendant. If the court had instead substituted some other word for "ordinary" which would have markedly changed the meaning of this instruction, Defendant might have reason to complain. But simply omitting this word, a word which by its own definition describes the usual, unexceptional status of things, did not alter the information being conveyed to the jury. Surely, it must be acknowledged that an unmodified "learning, judgment or skill" is

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indistinguishable from "ordinary learning, judgment, skill". Presumably, when talking about a person's learning, judgment or skill, without modification, it is understood that one is talking about these attributes in their ordinary sense and not in any extraordinary or exceptional sense. "Ordinary" is simply a neutral adjective that ordinarily adds nothing of significance to the word or phrase being modified, as in the comparison of the phrase "negligence" and "ordinary negligence" or "standard of care" and "ordinary standard of care". Without any such modifier placed before these words, there is no basis for concluding that the jury took the attributes of learning, judgment, and skill in anything other than their ordinary meaning. The view that the omission of this single word somehow altered this instruction to impose some form of strict liability upon Defendant simply doesn't make sense, either logically nor grammatically.

Furthermore, neither Plaintiffs' counsel in argument, nor any of Plaintiffs' witnesses in giving testimony, ever suggested to the jury that anything other than ordinary learning, judgment, or skill was expected of Defendant's employees.

Hence, the omission of this word "ordinary" would have had no influence upon the jury's evaluation of the evidence presented in this case.

F. THE ISSUES WERE FAIRLY AND ADEQUATELY PRESENTED

In terms of liability, this was not a complicated case for the jury to decide. No one contested that it was the responsibility of neonatal nurses in an NICU to maintain the security of a UAC, to use all reasonable precautions to prevent a UAC from becoming dislodged. All the jury was asked to resolve was the disputed question of whether the dislodgment of Brandon's UAC occurred despite the taking of all reasonable precautions in Defendant's NICU, or happened because proper care to prevent this from occurring had

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not been exercised.

In this context it cannot be said that the instruction given by the trial court defining professional negligence for the jury was either misleading or wrong. It basically told the jury that it was for the jury to determine what should or should not be done in an NICU "under the same or similar circumstances," that is, with respect to maintaining the integrity of a UAC in a gram newborn. Because all the evidence was clear and consistent concerning this -- what should be done, what must be done, is to use all reasonable care to maintain a UAC -- nothing in this instruction was inconsistent with what all the evidence presented had uniformly established.

Consequently, all of the lamentations about this instruction altering or unraveling the fundamental tenants of medical malpractice law must be viewed in a proper context. In this case this instruction defined professional negligence consistent with the evidence presented and did not in any way deprive Defendant of a fair trial. There were no issues here of whether the hospital had a physician-patient relationship with Brandon, nor any fear that the jury would hold Defendant liable absent proof of fault on the part of its employees. This instruction does not deny the basic premise that a hospital can only render treatment through its physicians and nurses (the "learning, judgment, and skill of its people"). This instruction did not imply that a "unit" (as opposed to the people staffing the unit) can commit malpractice.

All these arguments are made to disguise the simple fact that the instruction as crafted and presented by the court in this case did fairly and adequately present the issues that developed in this case to the jury. After exhausting all these criticisms, Defendant protests that it is "inconceivable" that such errors did not deprive Defendant of a fair trial.

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Actually, for the reasons shown, it is undeniable that the issues were fairly presented by the court to the jury, and that this maligned instruction, touching upon an uncontroverted matter, had no adverse impact whatsoever upon Defendant. Indeed, it is inconceivable how the court, carefully reviewing the facts of this case and the trial court's instructions in their entirety, can reach any other conclusion.

For these reasons, we ask that the June 13, 1994 Judgment of the Circuit Court be affirmed.

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IV. THE COURT OF APPEALS CORRECTLY AFFIRMED THE VERDICT AND JUDGMENT OF THE CIRCUIT COURT

Because this honorable court has granted Defendant leave to appeal the substantive issues presented in Defendant's application, we deem it unprofitable to respond to Defendant's sharp criticisms of the Court of Appeals' own resolution of these same issues. The merits of these issues are now before this honorable court to decide and its own decision will take precedence over that of the Court of Appeals.

We will only affirm our conviction that the Court of Appeals reached the right result in this matter in its decision of April 6, 1999, which this honorable court set aside due to unarticulated "unique circumstances." 462 Mich 859. We also here request this honorable court to give due consideration to the fact that the verdict and Judgment for Plaintiffs was entered in the Circuit Court eight years ago, and ask that the court act with diligence in bringing this matter to a conclusion.

For all the reasons stated above, that conclusion should be to affirm.

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RELIEF

For these reasons, Plaintiffs-Appellees pray this honorable Supreme Court will affirm the Judgment for Palintiffs entered in the Circuit Court on June 13, 1994, with costs.

Respectfully submitted,

SOMMERS, SCHWARTZ, SILVER & SCHWARTZ, P.C.

RICHARD D. TOTH (P21512)
Attorney for Plaintiffs-Appellees
2000 Town Center, Suite 900
Southfield, MI 48075
(248) 355-0300

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